STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
			B. WIN			04/03/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L		l	/ 10TH ST	
BRIDGE	AT GARDEN PLAZ	'A			APOLIS, IN 46234	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
PREFIX	(EACH DEFICIEN REGULATORY OR  This visit was for Complaint IN00.  Complaint IN00.  State deficiencie	r the Investigation of 104178.  104178 - Substantiated. s related to the 1ted at R0090, R0349,  April 3, 2012  005616  1005616  Characteristics of the 1ted at R0090, R0349,  Scher, RN	R00	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	en COMPLETION DATE  en en es s h in
	Supplemental sar	mple: 18				
	These state finding accordance with	_				
	Quality review c	ompleted on April 5,				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 1 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING  B. WING	00	COMPLETED 04/03/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BRIDGE	AT GARDEN PLAZ	A		/ 10TH ST APOLIS, IN 46234	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	2012 by Bev Fau	Ilkner, R.N.			

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 2 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012 FORM APPROVED OMB NO. 0938-0391

RO090  410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour at include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY		SURVEY					
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(D) major accidents.  If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.  (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.  (3) Obtaining director approval prior to the admission of an individual under eighteen  (18) years of age to an adult facility.  (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:  (A) employee's full name; and  (B) dates and hours worked during the past								
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(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past		requested by the	e resident or resident's legal					
admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past			-					
(18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past		(3) Obtaining dire	ector approval prior to the					
(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:  (A) employee's full name; and  (B) dates and hours worked during the past								
premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past								
worked that indicates the:  (A) employee's full name; and  (B) dates and hours worked during the past			_					
(A) employee's full name; and (B) dates and hours worked during the past		•						
(B) dates and hours worked during the past								
1. A. v. 1. v. (40)								
twelve (12) months.								
(5) Posting the results of the most recent		` '						
annual survey of the facility conducted by								
state surveyors, any plan of correction in								
effect with respect to the facility, and any		•						
subsequent surveys. The results must be		subsequent surv	reys. The results must be					

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 3 of 16

NAME OF PROVIDER OR SUPPLIER  BRIDGE AT GARDEN PLAZA  (X4) ID  PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.  (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the	AND PLAN OF CORRECTION	(X2) MULTIPLE C	00	COMPLETED 04/03/2012		
BRIDGE AT GARDEN PLAZA  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.  (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the			B. WING	ADDRESS CITY STATE 718 CO		, _ U   L
BRIDGE AT GARDEN PLAZA  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.  (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the	NAME OF PROVIDER OR SUPPL	DER OR SUPPLIER			JDE	
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.  (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the	BRIDGE AT GARDEN PL	ARDEN PLAZA				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.  (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the				PROVIDER'S PLAN OF CORR	RECTION	(X5)
available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the	· `			CROSS-REFERENCED TO THE AF	PPROPRIATE	COMPLETION DATE
	available for eplace readily a notice posted (6) Maintaining by the division two (2) years a available for in public upon reBased on int failed to not an unusual of the facility has the Administinform the Sextent of the actions that further spreasymptoms.  21 residents symptoms of potential to a the assisted.  Findings incomplete the pion a.m., the indicated the outbreak in the affected both.	railable for examination in the facility in a face readily accessible to residents and a stice posted of their availability.  Maintaining reports of surveys conducted the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the division in each facility for a period of the facility for a period of the division in each facility for a period of the facility facility for a period of the facility facility for a period of the facility facility facility for a period of the facility faci		A. With Respect to the to Notify the State Age an Unusual Occurrence It had been reported to Administrator that the H Department had been reand the miss communic that the County Health Department was contained their obligations of Health. Both the Administrator than the State Dof Health. Both the Administrator than the State Dof Health. Both the Administrator than the State Dof Health within 24 hours of the epidemic outbreak.  B. With Respect to How Facility will Identify Sin Reporting Obligations Future:  The facilities Infection of Policy now states that a "epidemic outbreak" is a contagious infection of involves 20% of the cermore. Either the Administrator their direction, the Recare Director shall report occurrence to the State Department of Health. Contagious Infection True with a system on the state of the State Department of Health.	e Failure ency of te: the dealth notified cation was cted epartment ministrator Director gations to ment of of an  w the milar in the Control an defined as event that nsus or nistrator, or esident ort the A racking acking all	04/18/2012

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 4 of 16

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN			04/03/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R		8614 W	10TH ST		
	AT GARDEN PLAZ	ZA		INDIAN	APOLIS, IN 46234		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG	implemented to allow the staff	DATE	
		rator further indicated			easily identify an epidemic		
	they notified t	the Marion County			outbreak.		
	Health Depart	ment, who brought					
	out a kit [used	I for samples], but by			C. With Respect to What Systemic Measures have bee	an l	
	the time we go	ot it, the outbreak was			put in Place to Address the	; <b>"</b>	
	over. I don't think we have				Stated Concern:		
					The Contagious Infection		
	anything since that time."				Tracking Log shall be a part of	:	
			the daily shift change and reviewed at morning report.				
	During intervi	ring interview on 04-03-12 at Nursing is instructed to report to		to			
	9:30 a.m., the Resident Care Director indicated she was aware				the Resident Service Director,		
					Administrator, or their designa	te,	
		nts had gotten ill and			any occurrence that equals or exceeds 20% of the resident		
					census. The Resident Care		
	*	she instructed the			Director has reviewed the		
	_	o "quarantine" all			Infection Control Policy and		
	residents to th	eir rooms/apartments.			Procedures. The Resident Ca Director will ensure clinical rec		
					documentation for residents'	old	
	The Resident	Care Director			experiencing viral signs and		
		notified the Marion			symptoms, to include		
					physician/family notification, interventions and resident		
	· ·	h Department on			response to the interventions.		
		ne outbreak, but failed					
	to notify the S	State Agency of the			D. With Respect to How the		
	epidemic.				Plan of Corrective Measures		
					will be Monitored: The Resident Care Director sh	nall	
	Additional int	erview on 04-03-12			review the Contagious Infection		
	at 10:30 a.m., the Dietary Supervisor indicated that he as well				Tracking Log on a weekly basi		
					assure that all contagious	.	
					infections are being recorded a that there has not been an	and	
	as 1 or 2 serve	ers and the "dessert			unusual occurrence of an		
	lady" contracted the illness and epidemic outbreak that had not		ıt				
	were off work	<u>.</u>			been reported to themselves,		
		-			Administrator or their designat	e.	

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 5 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COMF	E SURVEY LETED 3/2012
NAME OF P	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP C / 10TH ST	ODE	
BRIDGE	AT GARDEN PLAZ	'A		IAPOLIS, IN 46234		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG		ding relates to	TAG	This Plan of Correction in place no later than A 2012.	n will all be	DATE
			1			

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 6 of 16

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUII		00	04/03/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	<b>(</b>			10TH ST	
BRIDGE	AT GARDEN PLAZ	Ά		INDIAN	APOLIS, IN 46234	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
R0349	410 IAC 16.2-5-8			1710		BATE
		- Noncompliance				
	· ' '	ust maintain clinical records t. These records must be				
		er the supervision of an				
		facility designated with that				
	responsibility. The records must be as follows:  (1) Complete.					
	(2) Accurately documented. (3) Readily accessible.					
	(4) Systematically organized.					
	Based on reco	•	R03	49	A. With Respect to the Facili	04/18/2012
e	interview, the	facility failed to			Failure to Ensure Complete Clinical Records:	
	*	ete clinical records, in			An in-service will be held with	
	•	dents contracted			nursing and dietary associates	s to
	signs and sym	ptoms of a virus, the			review the management of epidemic outbreaks and clinic	al
		ailed to document an			documentation requirements .	
	assessment of				B. With Respect to How the	
	condition in th	neir clinical record for			Facility will Identify Similar	
		s sampled for the			Record Keeping Obligations	in
		a sample of 4 and 7			the Future: The Resident Care Director sl	hall
	of 18 supplem	-			spot check the individual resid	
	• •	esident's "B", "H", "I",			charts against the Contagious Infection Tracking Log to assu	
	"J", "L", "N",				that records are being maintai	ined
	, , , ,	1.			as required. This will be done part of the weekly review of the	
	Findings inclu	ide:			Contagious Infection	c
					Tracking Log Infection Contro	
	During intervi	ew on 04-03-12 at			education will be part of New Associate and Annual Orienta	
	9:00 a.m., the				for nursing and dietary	
	,	facility had a "flu"			associates.	
		ebruary [2012] and it			C. With Respect to What	
		the residential and			Systemic Measures have been	en
	arrected bottl	the restuctional allu			put in Place to Address the	

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 7 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/03/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
PRIDCE	AT GARDEN PLAZ	7.0		/ 10TH ST IAPOLIS, IN 46234	
				1AFOLIS, IN 40234	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
PREFIX TAG	independent lindependent lindep	iving communities."  iew on 04-03-12 at Resident Care ated she was aware ints had gotten ill and she instructed the o "quarantine" all ieir rooms/apartments  the Resident Care wed the 24 hour book the names of the the date the residents as and symptoms of s.  as follows:  rsday - Resident's "B"	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	th king enee

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 8 of 16

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 04/03	LETED	
	PROVIDER OR SUPPLIER AT GARDEN PLAZ		8614 W	ADDRESS, CITY, STATE, ZIP C / 10TH ST APOLIS, IN 46234	ODE	
	SUMMARY S (EACH DEFICIENT REGULATORY OR During record at 12:00 p.m., for Resident's "L", "N", "O", information of to the viral out to the viral out the Exit Confector aware the nurs document in the signs or symptem had experience.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) review on 04-03-12 the clinical records "B", "H", "I", "J", and "P" lacked any rassessment related			IOULD BE	(X5) COMPLETION DATE
	outbreak. This State Fin Complaint IN	_				

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 9 of 16

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			04/03/	2012
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					10TH ST		
BRIDGE	AT GARDEN PLAZ	Α		INDIAN.	APOLIS, IN 46234		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup> DEFICIENCY)	ΓE	COMPLETION DATE
R0407	410 IAC 16.2-5-1			1710	<u> </u>		DATE
		- Noncompliance					
	· · ·	ust establish an infection					
		that includes the following: t enables the facility to					
		of known infectious					
	symptoms.  (2) Provides orientation and in-service education on infection prevention and control, including universal precautions.  (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.						
		mmunizations. mmunicable disease to					
	public health aut						
	Based on record review and R0407		07	A. With Respect to the Facilit	:у	04/18/2012	
	interview, the	facility failed to have			Failure to Establish an Infection Control Program that		
	an effective in	fection control			Includes the Following: A		
	program, in th	at when the facility			system to 1) Analyze, 2)		
	had a flu like o	outbreak [Noro			Orientate and Educate, 3) Inform Residents and 4) Rep	ort	
	virus], which i	ncluded symptoms of			to Health Authorities:		
	nausea, vomiti	ing and diarrhea, the			The Infection Control Manual Policy and Procedures have be	een	
	facility failed	to ensure a system			reviewed by the Resident Care	9	
	was in place w	hich included the			Director. The newly developed Contagious Infection Tracking		
	implementatio	n to track and			Log has been added to the Po	licy	
	monitor the su	rveillance of the			and Procedure include the following:		
	epidemic for 1	of 1 infection			1. The Log enables the facility to analyze patterns of known infectious symptoms.		
	control progra	ms reviewed.					
	This deficient	practice effected 3 of			2. The Manual includes an		
	4 residents san	_			Infection Control Orientation fo		
	Norovirus and	18 of 18			Nursing and Dietary Associate 3. The Manual also includes	8.	
	supplemental s	sampled residents but			General Resident Care that		
	had the potent	ial to effect the entire			includes Resident and Family Education		
	residential pop	oulation at the			4. The Log has established lev	els	

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 10 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
			B. WIN	IG		04/03/2012	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	KO VIDEK OK SOIT EIEN				10TH ST		
BRIDGE	AT GARDEN PLAZ	'A		INDIAN	APOLIS, IN 46234		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETI	ION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		5.112	
	, , ,	dents "B", "C", "D",			at which time the staff is to info		
	"E", "F", "G",	"H", "I", "J", "K",			and the Administrator whom ha		
	"L", "M", "N", "O", "P", "Q", "S", "T", "U", "V", and "W"].				been trained to notify the State		
					Regulatory Office and State		
	1,0, ,,	ana w j.			Department of Health of any		
					epidemic occurrences.  The outlined procedures shall	ne	
	Findings inclu	de:			adhered to from this time forwa		
	During intervi	nterview on 04-03-12 at  B. With Respect to How the					
	9:00 a.m., the Administrator indicated the facility had a "flu"				Facility Insure that these	_	
					Procedures will be Maintaine	d	
					in the Future: The continued education of the		
	outbreak in February [2012] and it				Infection Control and the	,	
	affected both t	the residential and			Contagious Infection Tracking		
	independent li	ving communities."			Log shall be part of the New H	ire	
		rator further indicated			Orientation and In-Service training forl nursing and dietary	,	
		he Marion County			associates.		
		·					
	_	ment, who brought			C. With Respect to What		
	out a kit [used	for samples], but by			Systemic Measures have bee	n	
	the time we go	ot it, the outbreak was			put in Place to Address the Stated Concern:		
	over. I don't t	hink we have			The Resident Care Director sh	all	
	anything since	that time "			maintain a log of Orientation		
					attendance and sign-in sheets		
	Di	ann an 04 02 12 4			in-Services on Infection Control and the Contagious Infection		
		ew on 04-03-12 at			Tracking Log.		
	9:30 a.m., the						
	Director indicate	ated she was aware			D. With Respect to How the		
	that 17 resider	nts had gotten ill and			Plan of Corrective Measures		
		and she instructed the			will be Monitored: The log of Orientation and		
	nursing staff to "quarantine" all				In-Services on Infection Contro	ol .	
		•			and the Contagious Infection		
	residents to the	eir rooms/apartments.			Tracking Log will be reviewed		
					along with the Infection Control  Manual by the Administrator or		
			1		I manual by the Authinistrator of	'	

State Form Event ID: ZEPS11 Facility ID: 005616 If continuation sheet Page 11 of 16

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI <b>04/03</b>	
	ROVIDER OR SUPPLIER		8614 W	ADDRESS, CITY, STATE, ZIP CODE V 10TH ST JAPOLIS, IN 46234	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	A request was facility infecti	made to review the on control		an annual basis.  This Plan of Correction wil	I all be	
	surveillance de Care Director titled "Contag Tracking." The contained 3 has Two of the entrapecific reside been identified difficile colitis handwritten en Virus - Feb. [Feb. 2012 - commutagratment]."  The document names, the first symptoms were intervention and the Resident of indicated on 0 that although the Infection Trackincomplete, the	ata. The Resident provided a document ious Infection his document andwritten entries. Aries indicated and mames who had did with Clostridium at the state of the		This Plan of Correction will in place no later than Janu 2012.		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	COMP	E SURVEY PLETED 3/2012		
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  The Resident Care Director		ID PREFIX TAG	PREFIX PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECT PROVIDER'S		(X5) COMPLETION DATE		
		24 hour book and						
	1 *	names of the residents						
		ne residents displayed						
	signs and sym	ptoms of the virus.						
	The data was	as follows:						
	02-16-12 Thu	rsday - Resident's						
		'F" contracted the						
	virus.							
	02-17-12 Frid	ay - Resident's "G",						
		J" contracted the						
	virus.							
	02-18-12 Satu	ırday - Resident "K"						
	contracted the virus.							
	02-19-12 Sun	day - Resident's "C",						
	"D", "L", "M"	', "N", "O", "P" and						
	"Q" contracted	d the virus.						
		nday - Resident "S"						
	contracted the	virus.						
	Although the							
		above residents with						
	signs and sym	ptoms of the Noro						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPI 04/03			
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
TAG	virus, the Resi indicated on 0 p.m., she was Residents "U" on 02-18-12], [contracted the and Resident 'virus on 02-22]. The Noro Virus on 02-22. The Noro Virus on the first flosecond floor, a third floor.  Further intervirus on 02-22 in the contraction of the first flosecond floor, a third floor.  Further intervirus on 02-22 in the contraction of the first floor.  Further intervirus on 02-22 in the contraction of the contractio	ident Care Director 4-03-12 at 12:00 unaware that [contracted the virus "T" and "V" e virus on 02-19-12] "W" contracted the 2-12.  us effected 5 residents or, 8 residents on the and 8 residents on the and 8 residents on the example at the example	TAG		APPROPRIATE	DATE		
	Additional int at 10:30 a.m.,	erview on 04-03-12 the Dietary						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			ì í	(X3) DATE SURVEY COMPLETED	
			A. BUIL B. WINC			04/03/	/2012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
BRIDGE AT GARDEN PLAZA					APOLIS, IN 46234		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	Supervisor indicated the work during the Although the I Director indicatinstructed the "quarantine" the room/apartment taken until she residents with of the virus.  During an interesident success and the wird and it indicated the with the resident success and the success are success and the success and the success and the success and the su	licated that he as well as 1 or 2 e "dessert lady" illness and were off ne outbreak.  Resident Services ated she had nursing staff to ne residents to their nt, this action was not e was aware of 17 signs and symptoms  rview on 04-03-12 at oncerned family ated she as well as family members virus after visiting ent over the weekend "It was such an s worried about the		TAG			DATE
	Practitioner ca	me in to the facility					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	— COMI	E SURVEY PLETED 3/2012
NAME OF PROVIDER OR SUPPLIER  BRIDGE AT GARDEN PLAZA			8614 W	ADDRESS, CITY, STATE, ZIP ( 1/10TH ST APOLIS, IN 46234	CODE	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION
TAG	on Tuesday [0] when she four [in reference the Practitioner] do her other visit returned to see following week.  The Resident indicated she in County Health 02-20-12 of the to notify the Stepidemic.	tidn't come back for that week, but the resident's the ethe resident's the ek."  Services Director motified the Marion in Department on the outbreak, but failed that Agency of the ether to ding relates to	TAG	DEFICIENCY)		DATE

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